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Indiana State
Department of Health
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We are pleased to present to you the 2004 and 2005 Annual Report of the Interagency Council on Black and Minority Health. In addition, we present the Action Plan for positively impacting the six recommendations of the Council. The Action plan calls for various state agencies and other state stakeholders to take affirmative steps to improve:

- Consumer awareness of health resources,
- Effectiveness of health education materials,
- Educational efforts to improve individual health choices, and
- Ability of healthcare providers to provide culturally sensitive services,

all with an end to improving access to healthcare services and to reducing health status disparities in minority communities and individuals.

We look forward to providing you with a report in 2006 outlining our success in implementing this Plan.

Sincerely,

SHELVY KEGLAR, Ph.D.
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Interagency Council on Black and Minority
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The Indiana State Department of Health serves to promote, protect and provide for the public health of people in Indiana

**The 2004-2005 Annual Report
of the
Interagency Council
on
Black and Minority Health**

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1. Breaux, Billie, Indiana State Senator, Indiana General Assembly (Democrat)
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4. Daniels, Mitch, Indiana Governor or Governor designee
5. Griffin, Lynne, American Heart Association
6. Indiana Local Health Departments
7. Indiana Office of Medicaid Policy and Planning
8. Indiana Division of Family and Children
9. Indiana Department of Correction
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15. Requiz, Carolin, MS, Director of the Hispanic/Latino Division, Indiana Minority Health
Coalition
16. Rodríguez, Henry, M.D., American Diabetes Association
17. Sanders, Charles E., M.D., Indiana State Medical Association
18. Smith, Lynn, Department of Mental Health and Addition, Indiana Family & Social
Services Administration
19. Thomas, Booker, Public Healthcare Facility
20. Williams, Edward L., M.D., Indiana Hospital and Health Association
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Preface

The Interagency Council on Black and Minority Health (ICBMH) was established by the Indiana state department under Indiana Code 16-46-6 to ameliorate the overall health and well-being of racial and ethnic minorities in Indiana using diverse members of key stakeholder entities. More specifically, the ICBMH has been charged to do the following:

1. *Identify and study the special health care needs and health problems of minorities.*
2. *Examine the factors and conditions that affect the health of minorities.*
3. *Examine the health care services available to minorities in the public and private sector and determine the extent to which these services meet the needs of minorities.*
4. *Study the state and federal laws concerning the health needs of minorities.*
5. *Examine the coordination of services to minorities and recommend improvements in the delivery of services.*
6. *Examine funding sources for minority health care.*
7. *Examine and recommend preventive measures concerning the leading causes of death or injury among minorities*
8. *Examine the impact of the following on minorities:*
 - (A) *Adolescent pregnancy.*
 - (B) *Sexually transmitted and other communicable diseases.*
 - (C) *Lead poisoning.*
 - (D) *Long term disability and aging.*
 - (E) *Sickle cell anemia.*
9. *Monitor the Indiana minority health initiative and other public policies that affect the health status of minorities.*
10. *Develop and implement a comprehensive plan and time line to address health disparities and health issues of minority populations in Indiana.*

Council members serve a term of two (2) years and are expected to meet quarterly. It is also expected that council members collectively submit a report to the general assembly before

November 1 of each year to include the findings, conclusions, and recommendations of the ICBMH.

For its 2004 report, ICBMH decided to place specific emphasis on the following areas:

- Access to care:
 1. Disparities in insurance status
 2. The shortage of minority healthcare providers
 3. Cultural competency
 4. Awareness of healthcare resources
- Obesity:
 1. Adult Obesity
 2. Childhood Obesity

Introduction

In light of educational and technological advancements in medicine, patient care, and preventive health services; equality and justice for all has not been reached, especially among racial and ethnic minorities across the U.S. This is evident in the continual disproportionate representation of minorities suffering from various preventable health conditions. For example, racial/ethnic minorities represent 27% of the U.S. population, but yet they account for 66% of adult AIDS cases, 82% of pediatric AIDS cases, over 50% of Hepatitis B cases, and 80% of all reported tuberculosis cases between 1991 – 2001 (CDC & OMH). Racial and ethnic minorities also have higher rates of heart disease, cancer, diabetes, infant mortality, syphilis, obesity, and end stage renal disease than non-minorities (CDC, OMH, and Centers for Research on Minority Health, University of Texas). In Indiana racial and ethnic minorities represent slightly more than 14% of the population but die at almost twice the rate of non-minorities from heart disease, cancer, stroke and diabetes (ISDH, 2002).

It is estimated that if current birth and immigration trends continue, racial and ethnic minorities will become the majority in 2040, which the Hispanic population will increase by 21%, Asian 22%, African American 12%, and the Caucasian population 2%. Therefore, a proactive community centered approach must be employed at this point to address health disparities while it's more manageable. A solution in 2040 to resolve disparities will be too late, particularly considering spiraling healthcare costs already experienced today, which is further exacerbated in minority populations that still tend to receive healthcare services too late.

The United States Department of Health and Human Services suggests that the origin of health disparities include: poor education, unhealthy behaviors, socio--economic status, poverty (inadequate financial resources), direct and indirect manifestations of discrimination, lack of health insurance, geographic location, and environmental factors.

The Institute of Medicine (IOM) agreed that the disparities in healthcare can occur as a result of the organization and operation of healthcare systems; patient's attitudes and behaviors; and prejudices, biases, and uncertainty of health care providers when treating minorities.

The ICBMH is releasing this report to further explore specific issues that significantly contribute to existing health disparities and provide recommendations that can be employed by state/local partners to better achieve success in eradicating disparities in these areas. In particular, this report looks at issues related to access to care (such as health insurance, the shortage of minorities in health professions, cultural competency, and awareness of healthcare resources) and obesity.

ACCESS TO HEALTHCARE

Disparities in Insurance Status

One of the most influential factors affecting how soon a person will get health care and whether that individual gets the best care available is determined by insurance coverage. In 2002, 20.2 percent of African Americans and 32.4% of Hispanic/Latinos were uninsured, compared to 11.7 percent of whites. According to the Alliance for Health Reform (October, 2003), individuals who are uninsured or under insured are less likely to receive appropriate health care: if they receive any care at all. Unfortunately, some of these uninsured individuals suffering from particular health conditions tend to live a poorer quality of life and die sooner. These problems are further exacerbated in racial and ethnic minority communities. For example, Latinos are almost three times as likely as whites to be uninsured, and African Americans have almost twice the un-insurance rates of whites (Alliance for Health Reform, 2003).

The Alliance for Health Reform (October, 2003) reports that minorities that do have insurance are almost three times as likely as whites to be covered by publicly funded programs such as Medicaid, and are less likely to have employment-based coverage. This can be problematic considering some health practitioner responses to individuals covered by programs such as Medicaid. Some practitioners overtly refuse to see Medicaid patients, while others restrict the number of Medicaid patients seen in their facility. This practice is attributed to Medicaid's often low reimbursement rates, which many providers view as an unfavorable source of health coverage from patients.

The Institute of Medicine (IOM) report makes a few recommendations to address these barriers. One recommendation is for state programs that mandate the enrollment of Medicaid beneficiaries in managed care plans pay for plans at rates that give enrollees access to the same health plans that serve substantial proportions of privately insured patients. Also, the IOM report suggests that health systems insure that physician financial incentives do not overly burden or restrict minority patients' access to care. In addition, the IOM report encourages the use of community health workers and multidisciplinary treatment and preventive care teams; which could reduce the cost of some health services.

The Shortage of Minority Healthcare Providers

Although there are many factors that influence one's ability to access health care services, the low number of minorities entering the health field has been identified as one of the contributing factors for minority populations not accessing services. Thus, the impact of this shortage in minority health professionals not only has economic implications, but also influences the overall health status of certain minority groups.

According to several studies, cultural and language barriers adversely affect the health care of minorities resulting in a lack of understanding, confusion, fear and at times mistrust of non-minority health care providers (Yergan, LoGerfo and Dier, 1987; Schulman, Rubenstein and Chesley, 1995). Therefore, the inequality of health care is a major problem that is further exacerbated by the under representation of minorities who have achieved professional status in health careers, as well as the low numbers of minorities enrolled in college and universities offering degrees in dentistry, medicine, nursing, pharmacy, and allied health professions.

According to the 2000 U.S. Bureau of the Census, there were approximately 276,059,000 Americans; of which, 12.8 % was African American, 11.9% was Hispanic/Latino, 4.1% was Asian/Pacific Islander, and 0.8 % was Native Americans. Yet, when the population estimates are compared with the supplemental report of the 2000 Census on the number of racial and ethnic minority health care professionals for 2000, the percentages do not reflect the minority population changes. For example, although the Hispanic/Latino population comprised 11.9% of the population, they represented 6.4% of those reporting employment in the area of health services (U.S. Bureau of Census, 2000).

Indiana is no exception when it comes to a shortage of minority health care professionals. Although racial and ethnic minorities comprised approximately 12% of the total state population according to year 2000 census, minority health care professionals in the state were approximately 7 % of the 71,366 health care professionals in 1999. Of the 92 counties in Indiana, 56 are classified as medically underserved and 46 were classified as health professional shortage areas. Of these counties, 16 are identified in areas with significant minority populations (5000+) (see

attachment - maps of medically underserved and health professional shortage areas). Furthermore, minority health professionals tend to practice in larger cities in Indiana and as a result there is a mal-distribution of minority health care providers in the state. This is true for African American, Hispanic/Latino, Native American and Asian Pacific Islanders.

It is clearly evident that there is an overwhelming need to increase the number of racial and ethnic minority health professionals in the U.S. and Indiana. According to the American Medical Student Association (AMSA) (2002), there are some benefits to be achieved in increasing the number of racial/ethnic minority doctors. Some of the benefits noted are that racial/ethnic minority doctors will be more likely to:

- Care for the Underinsured
- Work in underserved areas
- Treat Medicaid patients

In order to achieve these benefits, many experts believe that improvements in the education system must be made. The AMSA reported on barriers noted from a survey conducted in 2002 revealing that racial/ethnic minority students encounter the following in the admission and matriculation process of medical school, which is believed to be similar for all health professions:

- Low MCAT (bias standardized testing)
- No under-represented minority (URM) Faculty
- No Role Models
- Low GPA
- Poor Science Preparation
- Court Decisions (affirmative action rulings)
- State is not Diverse
- Lack of Financial Aid
- No Community Support
- Low Achievement of Parents

Nationally, the Surgeon General has launched a campaign to eliminate health disparities and the Bureau of Primary Healthcare has a 100% access, zero disparities campaign. Both initiatives

recommend increasing the number of minority providers as a strategy for decreasing minority health disparities. The frameworks outlined in the campaigns, as well as in the Executive orders that originated out of the Office of Minority Health as a result of the campaigns, promote initiatives that will increase the number of minority health care providers.

In Indiana, we must adapt the national charge and make a valiant effort to minimize the barriers for minorities becoming health professionals. As Daniel J. Delaney states, Director of the Massachusetts Health Care for All, "physician diversity is not just important for Blacks, Latinos and other underrepresented minorities in medicine. It has important public health implications for the Commonwealth as a whole."

Cultural Competency

Background

According to the Institute of Medicine (IOM) report on Unequal Treatment, "a large body of published research reveals that racial and ethnic minorities experience a lower quality of health services, and are less likely to receive even routine medical procedures than are White Americans" (p. 3). In order to improve quality of care we must not examine just who is providing the service, but the quality of the patient-provider relationship. Racial and ethnic minority patients with or without health coverage complain that their "health care providers fail to provide complete information, are hurried in the provision of their care, and lack sufficient time to spend with them" (Barlett, 1999). Another complaint of patients is that doctors do not listen to their concerns and believe that the doctor's actions are the direct result of racism (Baldwin, 1996). However, many physicians believe that they make the best decisions they can under present time constraints with limited information from the patient and clinical uncertainty of a diagnosis.

To strengthen the doctor-provider relationships with racial/ethnic minorities we must address issues, such as the quality of the provider-patient interaction, the providers' awareness of cultural differences and the impact these differences can have when communicating with a provider.

Cultural issues

The role of culture in America's health care system is becoming more complex, as the U.S. becomes more culturally diverse. The complexity of culture is presenting the health care system with challenges that have significantly contributed to health disparities from preventable conditions being experienced by various diverse populations throughout the nation. Many of the challenges faced can be overcome by becoming more knowledgeable regarding cultural differences which will require more time, effort, repentance, as well as financial and human resources from the health care provider.

Culture

In order to better understand the issues surrounding culture, one must define it. Culture is defined as “the integrated pattern of human behavior that includes thought, speech, and beliefs of a racial, religious, or social group” (National Center for Cultural Competence). Culture is dynamic and on-going, and is a major factor in how health care services are provided by health professionals and how health care services are utilized by consumers (National Center for Cultural Competence). Failure to gain understanding of culture has led to unfavorable practices of some health professionals in rendering health care services and barriers for consumers attempting to access services. The lack of a culturally knowledgeable system is a major contributing factor in health disparities.

For example, the literature reflects that Hispanics are more likely to lack a source of on-going care (24%), while African Americans (14%) and Asian/Pacific Islanders (15%) are slightly more likely than Caucasians to lack a specific source of on-going care. Another example found in the literature shows that Hispanics, African Americans, other minority groups, and low income populations reported having less routine office or outpatient visits, as well as less receipt of medications and dental visits than Caucasians (IOM, 2002). Any effort used to address health disparities such as these requires that health professionals become culturally competent.

Cultural Competence

Cultural competence is a term that is becoming more popular, but is defined differently dependent upon who is asked. For the purpose of this report cultural competency is defined according to the National Center for Cultural Competence definition, which is:

A set of values, behaviors, attitudes, and practices within a system, organization, program or among individuals enabling them to work effectively cross culturally.

In health care, it can be referred to as the development and maintenance of interpersonal and professional skills to increase one's respect for, understanding of, and knowledge of the

differences between patient and practitioner values, lifestyles, norms, beliefs, and opportunities that influence every aspect of the health care delivery system (Henry Ford Health System). Cultural competence is a dynamic, ongoing, developmental process that requires a long term commitment and is achieved over time.

Although true cultural competence recognizes language and culture as being inseparable, in practice, it is usually divided into linguistic competence and cultural competence (Diversity RX). According to the Diversity Rx website, the separation of language and culture is partly attributed to the fact that the provision of linguistic services is more targeted and more easily measured than cultural services. Linguistic services tends to be more straightforward because it is easier to track the language needs of an individual client, whether that need was met, what points of contact in a facility require additional resources, and how efficient are linguistic services being provided (Diversity RX). Whereas, culturally competent services are not as clear.

Also, the Diversity Rx website reflects that culturally competent services are not as clear for a couple of reasons. One reason is that culturally competent services are more dependent on the ethics of an institution or the specific attitudes and practices of individual practitioners. Another reason is that culturally competent services are difficult to assess. It is challenging to determine whether or not a person's cultural needs or concerns were addressed and what impact this might have on their health outcomes. The Diversity Rx website stated that most general patient satisfaction surveys do not address these issues and may not reflect a true picture of satisfaction as many groups are not comfortable with direct expressions of dissatisfaction, no matter what their true experience; which is inclusive of racial and ethnic minorities. It is believed that the discontinuation of services is the only indication of unmet needs or offense.

In the proceeding paragraphs of this section, the ICBMH will discuss cultural factors that the literature indicates are major contributors to the health disparities crisis. These factors include: racism, fear, language, and health literacy.

Racism

According to the IOM, racial and ethnic healthcare disparities still remain when differences in treatment attributable to insurance, access to care, health status, and other factors are eliminated, thus indicating that these differences in care are based upon race or ethnicity.

The IOM report state that there are three factors that can lead to a health professional making a difference in their health care decision for minority patients vs. non-minority patients: 1) bias or prejudice against minorities, 2) greater clinical uncertainty when interacting with minority clients, and 3) beliefs or stereotypes about minorities. The report also indicated that health professionals that are influenced by their prejudice when providing healthcare services may be manifesting nonverbal behaviors reflecting anxiety, aversion, or avoidance as they interact with their minority clients rather than white clients. The IOM report stated that as a result of these types of provider-patient interactions, patients react by developing distrust of their health care provider, thus leading to the client not following treatment regimens and ultimately contributing to healthcare disparities.

Empirical support for the presence of racism among healthcare providers, as noted in the IOM publication, is limited but growing. Some of the studies supporting this issue are highlighted below.

Study #1 A study by Abreu (1999) assessed whether conscious or non-conscious stereotypes (Blacks vs. neutral words) would influence the clinical impressions of mental health professionals. This study finding showed that:

- Therapists primed with stereotype-laden words rated the patient significantly less favorably on hostility related attributes than therapists exposed to neutral words.
- Therapists can be affected by African American stereotypes in ways that produce negative or positive first impressions, depending on the nature of the attribute that is rated.

Study #2 In a study of primary care physicians' recommendation for pain management, Weisse et al. (2001) presented vignettes of patients suffering from identical symptoms of kidney stone pain, lower back pain, and as a control condition, sinusitis. Nearly 80% of the physician sample was white, while 15% were Asian American or Pacific Islander. This study finding showed that:

- Male physicians prescribed higher doses of hydrocodone for white "patients" than black "patients" suffering from back pain and renal colic, while female physicians prescribed higher doses of analgesic for black "patients" than white "patients".

Fear

The literature indicates that racial and ethnic minorities are more likely to express greater levels of mistrust of healthcare providers and the medical establishment than white Americans (IOM 2002). In doing so, minorities cite breeches of trust that occurred between minorities and the scientific and medical communities. The literature indicates that racial and ethnic minorities perceive higher levels of racial discrimination in healthcare settings than non-minorities (IOM 2002). For example, a study by La Veist, Nickerson, and Bowei (2000) found that African American patients were four times more likely than whites to believe that racial discrimination is common in doctor's offices, and were significantly more likely to mistrust the healthcare system. In another study conducted by Lillie-Blanton et.al. (2000), 30% of Hispanics and 35% of African Americans who participated in the study believed that racism is a "major problem" in healthcare, compared to 16% of the whites who participated in the study.

Language

Language is the words, the pronunciation, and the methods of combining them used and understood by a community. It is a systematic means of communicating ideas or feelings by the use of conventionalized signs, sounds, gestures, or marks having understood meanings. In America, the primary language read and spoken is English. However, there are nearly 14 million people that are not proficient in English. In Indiana, there are approximately 438,486 individuals

who are speaking a language other than English. Also, there are approximately 210 languages spoken in Indiana in which the minimum number of languages spoken other than English in any Indiana county is 6. (See appendix for listing)

If health professionals are unable to effectively communicate with their clients, it can lead to: misunderstandings, misdiagnosis, unnecessary testing, poor client compliance, inappropriate follow-up, and/or poor client satisfaction (IOM, 2002). For example, Hispanics, Asians, and those of lower socioeconomic status have greater difficulty accessing health care information. About 43% of adults report that it is “not very easy” to understand information from their doctor’s offices. Differences between racial and ethnic group data indicate that Asians (58%, compared with 41% of whites) and Hispanics (54% compared with 40% of non-Hispanic whites) have harder times comprehending doctor-provided health information.

In a study reported in the IOM publication, a hospital emergency department interpretation was only provided for 26% of the approximately 467 Spanish-speaking patients. Just over half (52%) of the Spanish-speaking patients who were seen without a translator felt that interpretation was not necessary, of the remaining 22% of the patients who did not receive interpretation services almost half (49%) received interpretation services by a physician or nurse. But when providers’ Spanish and the patients’ English were poor, an interpretator was not called in over one-third (34%) of the encounters. In these instances, 87% of patients felt an interpreter should have been called.

Under Federal Laws and Regulations, it is required that effective communication occurs between clients and health and social service providers. These include but are not limited to the following:

- Title VI of the Civil Rights Act of 1964
"No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."
- Executive Order 13166
August 11, 2000 Entitled:

"Improving Access to Services for Persons with Limited English Proficiency"

This applies to all federal agencies.

- Department of Health and Human Services

"...No persons may be subjected to discrimination on the basis of national origin in health and human services programs because they have a primary language other than English."
- HHS revised its Limited English Proficiency (**LEP**) Guidance in 2002; it delineates methods for compliance that **LEP** individuals have language assistance to access health care. Within this Guidance, **HHS** outlines that need for use of competent interpreters and translators and specifically points out that "self-identification as bilingual" is not an acceptable measurement for carrying out the complex tasks of interpreting and translating. The **HHS** Guidance included further recommendations about hiring qualified interpreters and translators, the use of telephonic interpreting, and noted the complications and ethical implications of using minors and family members.
- Department of Health and Human Services, Office of Minority Health

Cultural and Linguistically Appropriate Service standard number 6 requires that health care organizations must assure the competence of language assistance provided to LEP patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Health Literacy

Health literacy is a major problem for many individuals, particularly minorities, in accessing needed healthcare. This growing health literacy problem demands that our healthcare infrastructure puts forth a focused effort to immediately address it. Health literacy can be defined as the ability to read, understand and write (Baker, 2002). Health literacy can affect people of all ages, races, cultures, languages, educational levels and socioeconomic levels. Health literacy has a close relationship with education and involves a person understanding written materials in order to adequately communicate with his/her healthcare provider.

According to the U.S. Department of Education, National Adult Literacy Survey results, approximately 44 million people perform at the lowest of five skill levels on literacy tasks. Another study conducted by Educational Testing Service (ETS) called Literacy and Health in America revealed that the average proficiency of white adults on the Health Activities Literacy Scale (HALS) is significantly higher than the average proficiency of Black, Hispanic, and others groups. The differences among racial/ethnic groups reflect the influence of other variables such as education, resources and/or immigrant status. For example, Asian/Pacific Islanders, Hispanics, and those with low income status have greater difficulty accessing health care information (IOM, 2002).

Awareness of Healthcare Resources

There have been numerous studies conducted that illustrates that “lack of knowledge” is a major patient barrier to accessing health care. In order to be healthy, an individual must have the basic knowledge and understanding of what is good health and when should that individual seek attention for their health needs. Unfortunately, many Americans and Hoosiers do not possess this knowledge base.

According to a survey of patients and clients of health care and human service providers in Richland County, South Carolina, fifty-six percent of those who reported delaying seeking medical care did so because they thought their problems were not as serious as they actually were (Shi et al., 1996). Another study conducted in 1995 involving Medicaid and uninsured mothers in North Carolina identified barriers to obtaining adequate care for their children based on a lack of knowledge regarding the proper timing of childhood immunizations and lack of clarity regarding the safety of these immunizations (Lannon et al., 1995).

There are also studies that indicate having a lack of basic health knowledge may also influence an individual’s perceptions about preventive health. It has been documented that lower income and rural residents are not as likely as non-poor and urban residents to seek and receive preventive health care (OTA, 1990). Unfortunately, these medically indigent populations tend to seek healthcare when their health condition is more serious and urgent in nature.

Some experts believe that knowledge barriers may also be derived from a lack of functional literacy, which may lead to serious medication errors due to the inability to read and understand prescription labels or the doctor’s recommended instructions. This, of course, has a tremendous potential to affect the health of a person. Lack of functional literacy, in the context of inability to fill out paperwork, may also foster a sense of shame and promote the idea of the healthcare setting as an intimidating place (Baker et al., 1996).

It is believed that these issues are further exacerbated in racial and ethnic minorities, as the attainment and application of knowledge are often received within a cultural and language

context not easily recognized or understood by many health professionals. Therefore strategies must be employed to empower health professionals to better educate racial and ethnic minorities with health knowledge to assist in increasing health outcomes and reducing health disparities.

One of the first recommendations made by the Institute of Medicine for reducing racial and ethnic disparities in health care is to increase awareness of health disparities to the general public, health care providers, insurance companies, and policy makers. It was also recommended that more community-based health workers be utilized to reach some minority neighborhoods and the healthcare system as a whole. In addition, it was recommended that patient education programs be expanded to increase patients' knowledge of how to best access care, ask the right questions during clinical encounters, and participate in treatment decisions. Preliminary evidence indicates that culturally appropriate education through books and pamphlets, in-person instruction, CD-ROMs, or the Internet can increase the level of patient participation.

OBESITY

OBESITY

Overview

Obesity prevalence has increased in every state, in both sexes, across all age, race and socioeconomic groups. Two separate studies in the Journal of the American Medical Association concluded that poor diet and physical inactivity would most likely be the leading preventable cause of mortality in the next few years (Nation Conference of State Legislatures, Nutrition and Obesity, April 2004).

Overweight and Obesity Defined

Body weight is the result of genes, metabolism, behavior, environment, culture, and socioeconomic status (CDC). Overweight and obesity result from an energy imbalance involving eating too many calories and not getting enough physical activity. Behavior and environment play a large role in causing people to be overweight and obese, which are the greatest areas for prevention and treatment actions (CDC).

A person that has a body mass index (BMI) of 25 to 29.9 kg/mm is considered to be overweight. Whereas, a person that has a BMI greater than or equal to 30.0 kg/mm is considered to be obese (Healthcare Equality and Accountability Act).

The definition of childhood overweight and obesity varies from that of adults, but as in adults the determination is still made based largely on the BMI. Children are considered overweight when their BMI is between the 85th and 95th percentile. They are considered obese when their BMI is above the 95th percentile (IOM, 2004).

Overweight and Obesity Prevalence

Adult Obesity

In 2004, 62.2% of adult Americans were classified as either overweight or obese (U.S. Behavioral Risk Factor Surveillance System, 2004). In Indiana, there were similar high

percentages of individuals that were classified as either overweight or obese, as Indiana currently ranks 9th in the nation for adult respondents that are obese (ISDH, 2004). The high percentages of Indiana residents that are classified as overweight or obese were derived from the Indiana Behavioral Risk Factor Surveillance System (BRFSS) 2004 and data are reported by race and ethnic origin. Indiana respondents classified as overweight or obese were as follows:

- 61.8% White, non-Hispanic
- 72.4% African American, non-Hispanic
- 60.4% Hispanic
- 53.0% Other, non-Hispanic
- 61.6% Multi-racial, non-Hispanic

Of the Indiana BRFSS survey respondents in 2004, 78% reported eating less than five servings of fruits and vegetables daily. Hispanics had lower rates of individuals (19.7%) reported to have eaten 5 or more servings of fruits and vegetables daily, followed by multi-racial individuals (20.0%), Whites (21.8%), and other/more than one race (23.3%). 2004 BRFSS survey respondents also reported on physical activity carried out within the last month other than their regular job. Hispanics had lower rates of individuals (64.5%) reporting to have exercised, followed by African Americans (66.5%), Whites (75.8%), other race (80.7%), and multi-racial individuals (82.0%).

Childhood Obesity

Childhood obesity is not only a United States problem it is affecting children worldwide (American Medical Association (AMA), 2004). Nationally overweight in children has more than doubled since the 1970's. More than 15% of children and adolescents are now overweight. Solving this problem will require involvement on multiple levels from multiple disciplines.

According to a JAMA article the prevalence of overweight in children during the period of 1999-2002 ages 6- 11 year olds was 15.8%, and among 12-19 year olds was 16.1% compared to 11.3% and 10.5% respectively in 1988-1994. Non-Hispanic blacks and Mexican –American prevalence increased more than 10 percentage points between these two periods. Actual data

from NHANES states that during the time period 1999-2002 the prevalence of overweight in Non-Hispanic Black boys was 17.0% in ages 6-11 and 18.7% in ages 12-19; Non-Hispanic, Black girls was 22.8% in ages 6-11 and 23.6% in ages 12-19. For Mexican American boys the prevalence was 26.5% and 24.7%; Mexican American girls was 17.1% in ages 6-11 and 19.6% in ages 12-19, respectively.

The Youth Risk Behavior Survey (YRBS) is a survey of high school age youth. This survey covers six (6) categories of health risk behaviors including nutrition and physical activity. The Indiana 2003 YRBS results shows that almost 80% of those youth responding state that they ate less than 5 servings of fruits and vegetables per day during the past 7 days and nearly 79% of the youth drank less than 3 glasses of milk per day during the past 7 days. With respect to physical activity, just over 62% participated in vigorous physical activity, only 26.5% of youth participated in moderate physical activity, over 76% did not attend physical education class daily and 8.6% did not participate in any vigorous or moderate physical activity in the past 7 days. In regards to becoming overweight, 14.2% of youth were found to be at risk of becoming overweight and another 11.5% were found to be overweight. Clearly, this data supports other studies that show a direct correlation between poor nutrition, lack of physical activity, and obesity.

Obesity Challenges

There are varied reasons as to why overweight and obesity is increasing. This section will highlight the more notable reasons provided in the literature and by experts in the field. Oftentimes, many individuals are challenged in eating healthy for several reasons. Some of the more notable reasons include the following (AMA, 2004):

- Innate preference for sugar
- Addictive properties of dietary fat
- Sensory specific satiety
- Deprivation anxiety/tendency to binge
- Metabolic efficiency

- Sabotage, well intended and otherwise
- The food/mood connection

Therefore, any programmatic interventions employed must empower the individual to properly address any one of these reasons within their social context.

Also, there are cultural factors associated with the prevalence of obesity. For example, in the African American community, there is a prevalent mentality that being “heavy” is cute. Oftentimes, the entertainers that youth look to emulate are overweight or obese; for instance, the rappers Heavy D or the late Notorious B.I.G. The diet in the African-American community in particular has been affected by their history while being in the United States. When African Americans came from Africa and were made slaves in the United States, their native African diet changed to a diet that was high in fat. As slaves, they were able to burn the extra calories through energy expenditure. Unfortunately, the diet has not changed although the level of exercise to burn the calories has been greatly reduced. Further complicating this situation is a feeling with the community that obesity is not a big problem.

In regards to the Latina community, there was a study in California involving WIC participants from various neighborhoods. The purpose of the study was to examine within a cultural context, Latina mothers’ perceptions about children’s weight issues. The mothers in the study consistently reported that the health for young children was determined by their happiness, their participation in a loving, attentive family, and their nutrition and activity habits. Being moderately overweight in early childhood was not viewed as a problem as long as the child looks and feels good. When viewing pictures of children who were very thin to very heavy, mothers frequently said that the heaviest child looked healthiest because her hair was healthy and shining, her skin was full of life and she had a very happy expression (Crawford et. al., 2004). Also in this study, mothers expressed concern that thinness was associated with poor health, with thinness being especially worrisome to immigrant Latina mothers who considered malnutrition and intestinal parasites as a greater threat to the children than overweight.

In addition, interpersonal factors are critical in understanding the obesity epidemic. It is important to realize that families and parents play a very critical role in this process. Usually it is a family member or parent who is cooking for the family, particularly children, who can make a difference in overweight. For this reason it is up to this person to make sure nutritional choices are provided for the child, food is eaten in a timely manner, and that their child is getting adequate exercise.

However, this will be more effective if the parent models the desired behavior. Children often emulate what they see their parents do. If there is a lack of physical exercise or poor eating habits, then the child will likely fall into the same behavior pattern. A Swedish study on parental modeling revealed a very strong correlation between parental inactivity and child inactivity, but when looking at the correlation between physical activity and child activity the correlation is not very strong. The reason may be that adults often use health clubs to exercise and thus their children do not see them physically active. The children often see the parents come home and sit in front of the television. Children must see their parent's physically active and making healthy food choices.

Looking at physical activity as a whole, it generally drops as a person gets older. Walking trips around the neighborhood decreased by 50% from 1977 to 1995. Lack of safety is the major concern regarding walking in the neighborhood. Therefore one area that needs immediate attention is providing a safe area where people may walk/exercise. Another element that is contributing to obesity/overweight is television viewing. Children have been asked in surveys concerning their home environment. Surveys found that 58% responded that they usually have a TV on during meals, 49% had no rules concerning television viewing, and 42% of them have televisions turned on most or all of the time in their home (Roberts et. al., 1999). Furthermore 40% of children ages 5 to 7 years old and two thirds of children ages 8-18 years old have a television in their bedrooms (Roberts et. al., 1999). This data illustrates the need for parents to set rules regarding television watching.

Obesity: Economic Implications

The issues surrounding obesity has come close to rivaling tobacco (AMA). Tobacco is responsible for 440,000 deaths per year in the U.S. and costs \$75 billion in direct medical costs. Obesity is responsible for at least 300,000 deaths per year, and costs \$75 billion in direct health costs. Medical expenditures due to obesity ranged from a high of 7.4% of total health care to a low of 4%. It is estimated that Americans 18 to 36 and obese will generate 36% more medical expenses per year than those not obese (AMA, 2004).

Nearly half the costs of obesity are paid out of tax-supported health insurance plans (AMA, 2004). A study of obesity costs from 1998 to 2000 found that the rate of obesity in the general population was found to be 20%. It also revealed that 21% of Medicare patients were obese, most of whom are elderly, comprising 7% of the Medicare budget, which was approximately \$18 million. Among the poor and disabled this study found that 30% of the Medicaid population was obese comprising 11 of the Medicaid budget, which totaled to be \$21 billion. Collectively, obese patient in Medicare and Medicaid almost accounted for half (49%) of the total obesity related health expenditures in America (AMA, 2004).

In Indiana, the medical expenses for obesity related issues in the state of Indiana during 1998 and 2000 were estimated to be \$1,637 million dollars (CDC). Of which, 379 million Medicare dollars were spent and \$522 Medicaid dollars were spent during 1998 to 2000.

In addition, the obesity epidemic has led to many individuals seeking out invasive procedures to cope with their condition. There were approximately 80,000 stomach and intestine stapling surgeries performed in 2002 (CDC). This cost an estimated \$2.4 billion.

Obesity: Health and Social Implications

The cost of obesity extends beyond financial costs, as it is also attributed to causing death, disability, and lost productivity (AMA, 2004). Obesity is a risk factor for Type 2 Diabetes, heart disease, and arthritis. It is also connected to cancers including: endometrial, some breast, colon,

and kidney cancers. Additionally, obesity is a major catalyst of sleep apnea, gall bladder disease, back and joint disorders, and depression (AMA, 2004).

Obesity Case Study:

The Indiana State Department of Health (ISDH) conducted a survey of 14 county coalitions to see how they felt concerning the overweight/obesity problem. Ideas covered in the project included the coalition's views on childhood overweight as well as the community views, interventions put in place, barriers to the local community, and how childhood overweight fits into the overall goals of the coalition. In the end, personal interviews were conducted with nine local organizations. As stated earlier it is very important to have healthcare providers involved early in the process. Only 3 of 9 agencies reported having a physician as part of the board of directors, but in the other agencies there was at least 1 person from the healthcare industry who worked closely with the health coalition. Many of the counties were located close to a major university or family practice residency. This would allow access to resources for helping overweight patients. The most important issue to examine here is the view of how bad the problem really is from the prospective of the coalition and the community.

Coalitions viewed overweight/obesity as somewhat of a problem in one-third of the cases, one-third as very problematic, and one-third as extremely problematic. The reasoning behind their views pointed to two-thirds believing that nutrition is the most responsible for overweight/obesity while one-third believed lack of physical activity as most responsible for overweight/obesity. Furthermore, eight of nine agencies believe there is no or only a vague connection between obesity and chronic disease. As far as community beliefs are involved, five out of nine agencies believe the problem has become acceptable. There were multiple reasons cited such as parents thinking it was "cute" and parents being unaware of the problem.

For example, it is fundamental that the family or the support network of the child must be involved at the ground level. Physicians and other healthcare providers are the first persons to see and evaluate these children. Therefore, it is important for them to be involved with developing and implementing guidelines to treat children who are obese. The healthcare

network should also involve nurse, nurse practitioners, nutritionists, behaviorists and other support individuals.

Strategies to Reduce Obesity

According to experts at the American Medical Association, National Obesity Summit, the following are key elements that must be employed to effectively address obesity:

- ☐ Dietary education
- ☐ Promotion of exercise
- ☐ Stress reduction
- ☐ Mental health support
- ☐ Personalized disease management

Experts believe that if investments are made up front, then healthcare costs related to obesity will be lowered, productivity increased, and prevention and education reinforced.

Tables 1 through 3 below provides information on strategies that have been reviewed for effectiveness as reported in the “Guide to Community Preventive Services: Promoting Physical Activity.” The information in this guide contains information on what strategies that should be considered when planning and implementing scientifically proven and effective obesity initiatives in the community.

Table 1: Informational approaches to increasing physical activity

<u>Intervention</u>	<u>Recommendation</u>
Community-wide campaigns	Recommended (Strong Evidence)
“Point-of-decision prompts”	Recommended (Sufficient Evidence)
Classroom-based health education focused on information provision	Insufficient Evidence to determine effectiveness
Mass media campaigns	Insufficient Evidence to determine effectiveness
School-based physical education	Recommended (Strong Evidence)
Non-family social support	Recommended (Strong Evidence)

Table 2: Behavioral and social approaches to increasing physical activity

<u>Intervention</u>	<u>Recommendation</u>
Individually-adapted health behavior change	Recommended (Strong Evidence)
Health education with TV/Video game turnoff component	Insufficient Evidence to determine effectiveness
College-age physical education/ health education	Insufficient Evidence to determine effectiveness
Family-based social support	Insufficient Evidence to determine effectiveness

Table 3: Environmental and policy approaches to increasing physical activity

<u>Intervention</u>	<u>Recommendation</u>
Creation and/or enhanced access to places for PA combined with informational outreach activities	Recommended (Strong Evidence)
Transportation policy and infrastructure changes to promote non-motorized transit	In progress
Urban planning approaches – zoning and land use	In progress

RECOMMENDATIONS

In light of the facts presented throughout this report, the ICBMH has the following recommendations to aid in reducing health disparities and the associated issues highlighted:

1. Increase the number of racial and ethnic minorities recruited and retained in health professional schools through increasing financial resources for minority students, making available preparatory test-taking training, recruiting and retaining minority faculty to state funded universities and colleges, creating more opportunities for minority professionals to mentor minority students, working with families to develop educational and life goals, and providing more opportunities for free to low-cost tutorials for minority students seeking to enter or are enrolled in a health professional school.
2. Develop and/or enhance cultural competency skills of health practitioners through mandating cultural competency education in state supported health professional schools and cultural competency training for all health professionals practicing in the state of Indiana.
3. Improve the readability of health information distributed to the public through ensuring that the reading materials are culturally and age appropriate and do not exceed a 5th grade reading level, and translating materials into languages of the target audience.
4. Increase awareness of healthcare resources available in the community through increasing collaborations, using media venues, and participating in more community wide events for educational purposes.
5. Increase physical activity among youth through working with the Department of Education to increase the offering of physical education in schools, especially beyond elementary school and to expand healthy nutritional options during lunch and in vending machines at schools.

6. Increase healthy eating habits and physical activity through the development of programs that are more family oriented ensuring a holistic approach to reduce and eliminate the prevalence of overweight and obesity.

REFERENCES

1. Alliance for Health Reform. Closing the Gap: Racial and Ethnic Disparities in Health Care. October 2003. www.allhealth.org.
2. American Medical Association (2004). National Summit on Obesity: Obesity Prevention and Control. David L. Katz, MD, MPH, FACPM, FACP. Chicago, IL.
3. American Medical Association (2004). National Summit on Obesity: Health Politics with Dr. Mike Magee. Chicago, IL.
4. American Medical Association. (2002). Proceedings of the Educational Forum on Adolescent health: Adolescent \Obesity, Nutrition, and Physical Activity. 133 p.
5. Association of Operating Room Nurses, Inc. 2002
Optimize patient health by treating literacy and language barriers by Vicki Dreger.
6. Ayanian, J. Udvarhelyi, I., Gatsonis, C., Pashos, C., & Epstein, A. (1993). Racial differences in the use of revascularization procedures after coronary angiography. *Journal of the American Medical Association*, 269,642-6.
7. Association of American Medical Colleges. (2000). *Minority Graduates of U.S. Medical Schools: Trends, 1950-1998*. Washington, D.C.: Author.
8. Baker DW. (2002). Past Successes and Future Challenges. Presented at the Health Literacy: Leading Edge Practices 5th Annual Conference. Washington, DC, 2002.
9. Baldwin, D. (1996). A model for describing low-income African American women's participation breast and cervical cancer early detection and screening. *Advances in Nursing Science*, 19, 27-42.
10. Baldwin, D. & Nelms, T. (1993). Difficult dialogues: Impact on nursing education curricula. *Journal of Professional Nursing*, 9(6), 3343-346.
11. Byrne, M. (2000). Uncovering racial bias in fundamental nursing textbooks: A critical hermeneutic analysis of the portrayal of African Americans. *Unpublished Dissertation*, Georgia State University, Atlanta, GA.
12. Bartlett, D. (1999). The new health care consumer. *Journal of Health Care Finance*, 25, 44-51.
13. Binns H, Ariza A. Guidelines Help Clinicians Identify Risk Factors for overweight in Children. *Pediatric Annals* 2004;33:1:19-22.

14. Brand, R., Cronin, J., & Routledge, J. (1997). Marketing to older patients: Perceptions of service quality. *Health Marketing Quarterly*, 15, 1-31.
15. Collins, K., Hall, A., & Neuhaus, C. (1999). *U.S. Minority health: A chartbook*. New York: The Commonwealth Fund.
16. Crawford PB, Gosliner W. Counseling Latina Mothers of Preschool Children about Weight Issues: Suggestions for a new Framework. *J Am Diet Assoc*. 2004;104:387-394.
17. Dennison B, Boyer P. Risk Evaluation in Pediatric Practice-Aids in prevention of Childhood Overweight. *Pediatric Annals* 2004;33:1:25-30.
18. Dietz W, Gortmaker L. Preventing Obesity in Children and Adolescents. *Annu Rev Public Health* 2001;22:337-53.
19. Diversity Rx. *Models and Practices*. <http://www.diversityrx.org/HTML/MODELS.htm>.
20. Eissa M, Gunner K. Evaluation and Management of Obesity in Children and Adolescents. *J pediatric Health Care* 2004;18: 35-38.
21. Fitzgibbon M, Stolley M. Environmental changes may be needed in the prevention of overweight in Minority Children. *Pediatric Annals* 2004;33:1:45-49.
22. Fowler-Brown A, Kahwati L et al. *Am Fam Physician* 2004;69:2591-8.
23. Harris, L., Mungai, S., & Tierny, W. (2000). Satisfaction with care in minority patients. In C. Hogue, M. Hargraves, & K. Collins, *Minority health in America: Findings and policy implications from the commonwealth fund minority health survey*. Baltimore, MA: The John Hopkins University Press.
24. Henry Ford Health System. *Cultural Competency in Health Care*. <http://www.henryford.com/body.cfm?id=39402>.
25. Herholz, H., Goff, D., Ramse, D., Chan, F., Ortiz, C., Labarthe, D., & Nichaman, M. (1996). Women and Mexican Americans receive fewer cardiovascular drugs following myocardial infarction than men and non-Hispanic whites: The Corpus Christi Heart Project, 1988-1990. *Journal of Clinical Epidemiology*, 49(3), 279-87.
26. Hogue, C. (2000). Eating well, exercising and avoiding smoking: Health promotion among men and women in minority populations. In C. Hogue, M. Hargraves, & K. Collins, *Minority health in America: Findings and policy implications from the commonwealth fund minority health survey*. Baltimore, MA: The John Hopkins University Press.

27. Indiana State Department of Health. 2003 Indiana Youth Risk Behavior survey(YRBS) Data. www.in.gov/isdh/dataandstats/yrbs/tables.htm
28. Institute of Medicine of the National Academies. Preventing Childhood Obesity: Health in the Balance. National Academies Press. Washington, DC. September 30, 2004.
29. Institute of Medicine of the National Academies. Unequal Treatment: Confronting Racial and Ethnic Disparity in Health Care. National Academies Press. Washington, DC. March 2002.
30. Jones, J.H. (1981). *Bad blood: The Tuskegee syphilis experiment*. New York: Macmillan, Inc.
31. Leonard, T. (2001). Exploring cultural, ethnic and racial diversity in baccalaureate nursing education programs. *Unpublished Dissertation*, Georgia State University, Atlanta, Georgia.
32. MansonJE, Skerrit PJ. The escalating pandemics of Obesity and Sedentary lifestyle-A call to action for Clinicians. *Arch Intern Med*.2004;2004164:249-258.
33. National Center for Cultural Competence. *What is Cultural Competence?* <http://mchneighborhood.ichp.edu/geneticsmeeting1999/culturalcomppage.htm>.
34. National Institutes of Health. (2002). *Women of color health data book*. Office of the Director, Publication No.02-4247. Washington, D.C.: Author.
35. Nesbitt S, Ashaye M et al. Overweight as a risk factor in children: A focus on Ethnicity. *Ethn Dis*. 2003;14: 94-110.
36. Nutrition and Physical Activity-Overweight and Obesity. www.cdc.gov/nccdphp/dnpa/obesity/defining.htm
37. Ogden CL, Flegal,KM et al. Prevalence and Trends in Overweight among US children and Adolescents, 1999-2000. *JAMA*. 2002;288:1728-1732.
38. Olson E. Obesity Risks and Treatment Options. Powerpoint presentation
39. Satcher, D. (2000, May 11). *U.S. Public Health Service, Department of Health and Human Services Before the House Commerce Committee: Subcommittee on Health and Environment*, Washington, D.C.: U.S. Public Health Service, Department of Health and Human Services
40. Satel, S. (1997). Race for the cure: Does racism make you sick? *The New Republic*, 216 (7), 12-13.

41. Schwartz M, Puhl R. Childhood obesity: A societal problem to solve. *Obesity Reviews* 2003;4:57-71.
42. Smedley, B.D., Stith, A.Y., & Nelson, A.R. (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Institute of Medicine Report. Washington, D.C.: National Academy Press.
43. Smith, D. B. (1999). *Health care divided: Race and healing a nation*. Ann Arbor, MI: The University of Michigan Press.
44. Smith, L. (1997). Are we reaching the healthcare consumer? *Journal of Cultural Diversity*, 5 (2), 48-52.
45. U. S. Department of Health and Human Services, Agency for Healthcare Research and Quality. *National Healthcare Disparities Report*. Rockville, Maryland. July 2003
46. U.S. Department of Health and Human Services. (2002). *A Century of Women's health: 1900-2000. Office of Women's Health*. Washington, D.C.: Author.
47. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. www.cdc.gov/.
48. U.S. Department of Health and Human Services, Office of Minority Health. www.cdc.gov/omh/AMH/factsheets/.
49. U.S. Department of Commerce, Bureau of the Census. (2000). *Statistical abstract of the United States*, Washington, D.C.: U.S. Government Printing Office.
50. U.S. Department of Health and Human Services. (2000, January). *Healthy people 2010: National health promotion and disease prevention objectives*, (Conference Edition in Two Volumes), Washington, D.C.: Author.
51. Vonfange T. Obesity Among Minority Children in Indiana: The perspective from local Minority Health Coalition Coordinators 2004. Powerpoint presentation
52. Williams, D. R. (1999). Race, socioeconomic status and health: The added effects of racism and discrimination. *Annals of the New York Academy of Sciences*, 896,173-88.